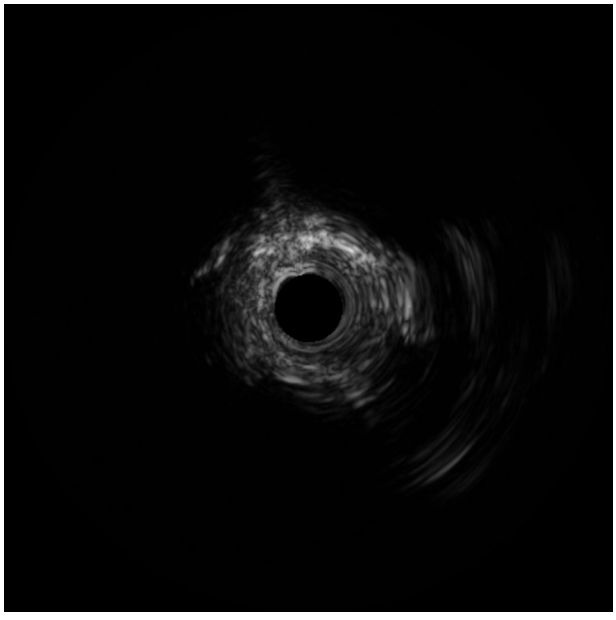
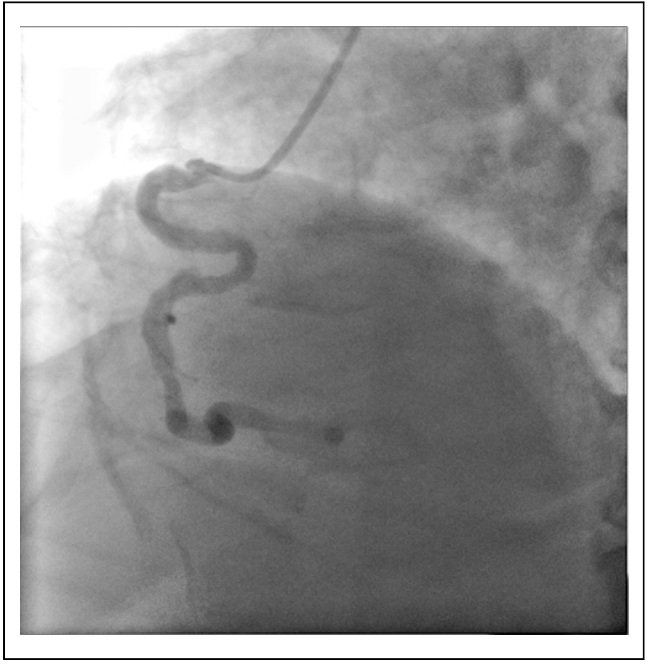


Case Summary.

1. Attenuated plaque was a predictor of slow reflow.
2. Longitudinal length of attenuated plaque was associated with slower flow.
3. Slow reflow could be prevented by distal protection.
4. Adenosine intracoronary injection was effective to treat slow reflow.



TCTAP C-148

OCT in a Tortuous Vessel

Yi Wei Chung[1]
[1]National Taiwan University Hospital, Taiwan

[CLINICAL INFORMATION]

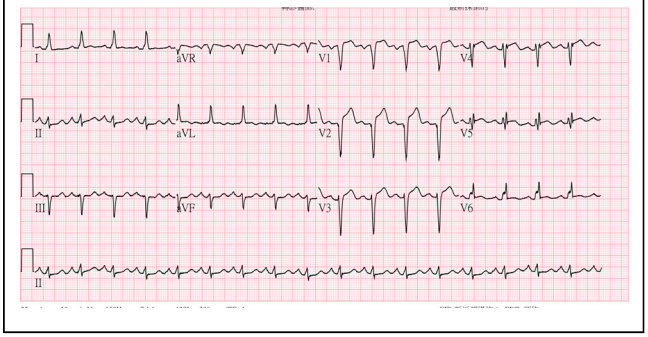
Patient initials or identifier number. YHH

Relevant clinical history and physical exam. This 54-year-old male patient is a case of hypertension, dyslipidemia, CAD and congestive heart failure. He suffered from STEMI in 2010, status post primary PCI to LAD. Later in 2011, LAD stent total occlusion was noted during follow-up catheterization. On 2014/09/06, he had another episode of acute coronary syndrome. The angiography showed an intimal flap in proximal RCA with TIMI 3 flow. After one month, he was admitted to deal with this RCA lesion.

Relevant test results prior to catheterization. ECG showed: QS pattern in precordial lead

Cardiac echo showed hypokinesia in LAD territory and apical aneurysm

Cardiac enzymes peak: CK 553U/L, CK-MB 82 U/L, TnI 10.5 ng/ml



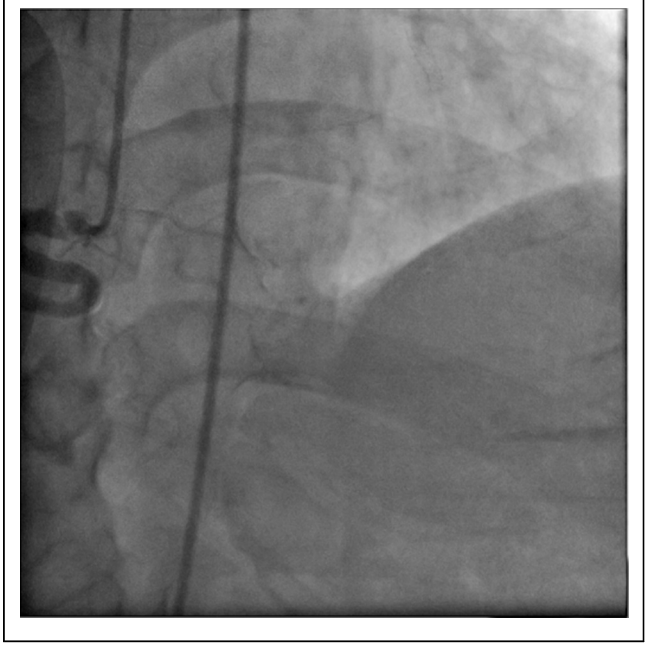
Relevant catheterization findings. Coronary angiography

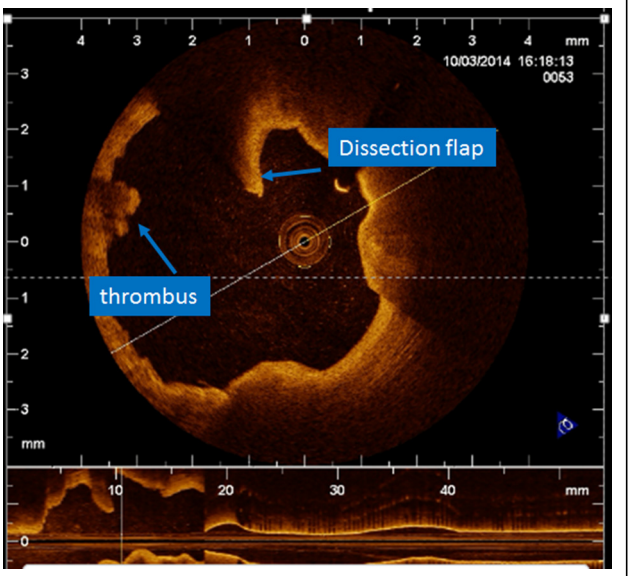
LM: patent

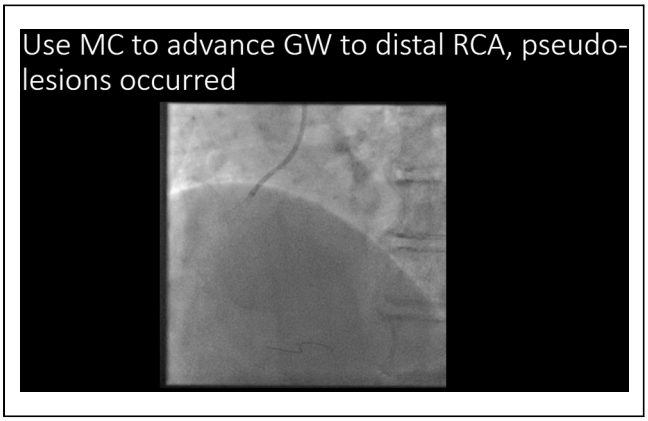
LAD: mid ISRS total occlusion with collaterals from RCA

LCX: proximal 60-70% stenosis

RCA: proximal intimal flap







[INTERVENTIONAL MANAGEMENT]
Procedural step. Target: RCA

1. Engage 6Fr. JR4 to RCA
2. Advance Sion wire to distal RCA
3. We could not advance OCT into proper position because the vessel is too tortuous
4. In order to advance wire more distally, we changed JR4 to AL 1 for better support
5. Then we advanced the Sion wire more distally to PLA
6. We still could not advance OCT into proper position
7. Use microcatheter to change Sion into Grand slam for extra-support
8. Pseudo-lesion was noted and the patient started to have chest pain
9. Advance OCT smoothly into proper position
10. Use OCT to check proximal lesion
11. the OCT showed dissection flap. And there is thrombus formation
12. POBA with Sprinter 4x12mm at p-RCA
13. Deploy a Liberte 5x12mm stent to cover the dissection
14. Post dilatation with Quantum Apex 5x8mm, up to 20A
14. Because the patient still had chest pain, we did not perform final OCT study
15. The final flow was good. And the patient's symptom got relieved after we removed the wire and GC

Case Summary.

1. OCT can provide detailed information regarding to plaque morphology. In our case, the angiography showed that the lesion might be a ruptured plaque or dissection. To have a better resolution and interpretation, we choose OCT rather than IVUS.
2. For adequate OCT positioning in a very tortuous vessel, we used microcatheter and extra-support wire to reach PLA
3. One of the OCT's limitations is the vessel tortuosity. In our case, the lesion is very proximal so we don't have to worry that the OCT may not reach to distal RCA.

To sum up, we demonstrated a successful OCT- guided PCI in a very tortuous vessel.

TCTAP C-149

FFR Is No Substitute for a Brain!

Hany Ragy,[1] Mohamed Ahmed Yehya Abdelrhman Sherif Hegab[1]
[1]National Heart Institute, Cairo, Egypt

[CLINICAL INFORMATION]
Patient initials or identifier number. GS

Relevant clinical history and physical exam.

- 49 year old patient, severe angina on exertion, (severe stable angina), smoker, not diabetic or hypertensive.
- No noninvasive testing.
- Coronary angiography and FFR done
- July 2010